apy, convincing evidence concerning these physical agents became available to the physician whose ethical ideas heretofore had limited him to drug therapy. For the benefit of those unfamiliar with the progress in the scientific and ethical interpretation placed on these methods in medical practice, the following is quoted.[3] "Physical therapy is a term employed to define the treatment of disease by various nonmedical means." It comprises the use of the physical, chemical and other properties of heat, light, water, electricity, massage, and exercise. There are certain definite indications for the use of some one or a combination of several of these physical agencies in the treatment of diseases, but to depend on these agencies solely, to use them in lieu of better proved methods, or to employ them without having first thoroughly studied the patient from the standpoint of diagnosis, is harmful practice. Some physical agencies may be used on the theory that "they will do no harm and may do some good." The psychologic element in their use impresses the patients, usually beneficially but occasionally to his detriment. The use of a certain method may become a habit with the patient, the physician or the technical assistant, so that the course of treatment is prolonged unduly. Again, manufacturers' agents—salesmen absolutely untrained in medical science—visit physicians, extolling the virtues of special physical apparatus, making unfounded claims as to curative values, and emphasizing the "money-making powers of these methods of treatment." In the above statement are facts, not fancies for consideration, but a practical knowledge must be acquired if the employment of physical agents are to be beneficially prescribed. Adequate hospital service must include a properly equipped physical therapy department with a physician in charge just as it maintains its clinical laboratories and roentgenological department. In the latter departments the directors interpet the medical findings largely for diagnostic purposes, while the director of physiotherapy must advise and supervise the application of the various physical procedures in a scientific and rational manner. Physical treatments must be measured by their effect. Physicians and patients have been discouraged and disappointed by poorly advised or administered physical therapy treatment. Norman Titus[4] draws "attention to the fact that by far the greatest part of physical therapy is medical common sense. An understanding of the pathology and of reaction desired in the patient can be called the common sense part. Three per cent of physical therapy is technical knowledge of whether the modalities can be applied effectively, conveniently, and with safety to the part to be treated and how those modalities will work when brought into play. Two per cent of physical therapy is the actual knowledge of the technique. Therefore, the common sense part of the subject is 95 per cent." With the growing recognition of the part physical therapy plays in general therapeutics and a better understanding of efficient administration of the various physical agents, more extended use is being made of them by physicians.

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3. J. A. M. A., 10, 16, 1926.
4. American Journal of Surgery, July, 1926, p. 15.

Proctology

TREATMENT of Rectal Prolapse of Infants and Children—To the parent, rectal prolapse in infants and young children is terrifying; to the physician it presents a situation calling for utmost ingenuity. Replacement is not usually difficult. Temporary retention with an adhesive strap in front of the anus gives temporary relief.

More permanent success demands correction of such irritative conditions as diarrhea, proctitis, or polypus; also the prevention of undue straining at stool, due to constipation. Defecation had best be in a recumbent position and often manual support of the perineum is necessary.

If this régime is faithfully carried out for a considerable period the tonus of the anal sphincter returns and the prolapsing tendency ceases. As Heald[1] has stated, however, such treatment is irksome, disagreeable, and often impossible. Despite faithful and intelligent care the child, by crying and straining, may cause a recurrence of the prolapse, thereby negativing previous efforts. In fact in most cases of considerable standing conservative methods are foredoomed to failure.

Heald[1] suggests a simple operative procedure consisting of replacing the prolapse in the etherized patient and then, through a speculum, after disinfecting the mucosa with mercurochrome, introducing two coarse silkworm gut sutures from within outward. The upper suture comes out with free ends on a level with and on each side of the sacrococcygeal notch. The second is one-half inch lower. They are tied over a compress and removed in two weeks.

The patient is in bed for three or four days, and bowel movements are prevented by an opiate and are later restored by an olive-oil injection. The results have been excellent both as to operative morbidity and final cures.

This method seems to be an independently evolved modification of the technique of Ekehorn,[2] further described by Tolken,[3] the end results of which have been discussed by Petren.[4] These Scandinavians use a single suture of heavy silk drawn out on each side of the lower end of the sacrum by a special mounted needle introduced into the rectum from the skin, under guidance of a finger inserted through the anus. The needle, being brought out through the anus, is threaded and withdrawn and the act repeated on the other side.

I have had eminent satisfaction with Ekehorn's method. It has not been necessary or possible to keep these children from brisk activity following the operation. No effort is made to prevent regular bowel action. There is always a slight fever. The results have been perfect.

This method of suspension is worthy of consideration in all young patients with severe or recurring prolapse and particularly if means are not at hand for faithful adherence to nonoperative treatment.

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1. Heald, C. L.: Surgery, Gynecology, and Obstetrics, Vol. 42, June, 1926.
2. Ekehorn, G.: Arclun. F. klin. Chir., Vol. 89, 1909.
3. Tolken, R.: Deutsche med. Wochenschr., 1915, No. 15.
4. Petren, G.: Acta Chir. Scand., Vol. 59, 1925.